



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TN 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS  
COMMITTEE FOR CLINICAL PERFUSIONISTS  
(800) 778-4123, ext. 532-4384 or Local (615) 532-3202, ext. 532-4384  
[www.tennessee.gov](http://www.tennessee.gov)

APPLICATION INSTRUCTIONS FOR LICENSURE AS A CLINICAL PERFUSIONIST  
APPLICATION CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Committee.**

**Licensure by Examination:**

**Done**

1. Complete, sign, have notarized and mail the application pages 1 through 6. \_\_\_\_\_
2. Attach to the application a clear, recognizable, recently taken passport size photograph of yourself. \_\_\_\_\_
3. Request that a graduate transcript from a perfusion education program, the educational standards of which have been established by the ACPE and approved by CAHEA or its successor, be submitted directly from the educational institution to the Administrative Office. The transcript must show the program has been successfully completed and carry the official seal of the institution. Complete and mail Attachment 1 to your graduate school. \_\_\_\_\_
4. If you are or have ever been licensed, certified, registered, or permitted by any state or country to practice as a Perfusionist or other health professional, you must complete and mail Attachment 1 to each and every state. Copies of Attachment 1 may be duplicated to accommodate each request. \_\_\_\_\_
5. Submit two (2) original letters of recommendation from medical professionals who can attest to your character as a Perfusionist. These letters must be written within the preceding 12 months, identify the individuals as medical professionals, and **must be originals** on the signator's letterhead. \_\_\_\_\_
6. Attach to the application a check or money order in the amount of \$360 made payable to the Committee for Clinical Perfusionists. \_\_\_\_\_
7. Cause to be submitted directly from ABCP proof of successfully completing the ABCP examination. See Attachment 2. \_\_\_\_\_
8. Criminal Background Check. For instructions to obtain a criminal background check, go to <http://tn.gov/health/article/CBC-instructions>. \_\_\_\_\_
9. Complete Attachment 5 – Declaration of Citizenship. \_\_\_\_\_

### **Licensure by Grandfather Clause**

**Done**

Any person who is currently actively practicing perfusion is eligible to receive a license as a clinical perfusionist upon further showing satisfactory proof of the existence on, January 1, 2000, of all of the following requirements:

1. Cause to be submitted to the Administrative Office items 1 through 6, listed above except item number 3. Also do number 8 and 9. 

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2. Proof of four (4) years experience within the immediately preceding six (6) years (between January 1, 1994 and January 1, 2000) operating cardiopulmonary bypass systems during cardiac surgical cases in a licensed health care facility. Proof that the experience obtained in that four (4) year period was obtained while the person's primary functions in that health care facility was operation of the cardiopulmonary systems. Satisfactory proof shall include written job descriptions from employing facilities that cover the entire four (4) year period and letters from each of the following officials at the licensed health care facilities attesting to the fact that all requirements have been met:
  - (a) a cardiac surgeon(s);
  - (b) applicant's immediate supervisor(s), and
  - (c) the chief of medical staff.

All documents must be submitted directly from the employing facility or signatory to the Committee's Administrative Office. 

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### **Licensure by Reciprocity**

**Done**

To become licensed in Tennessee as a clinical perfusionist based on licensure or certification in another state, an applicant must:

1. Cause to be submitted to the Administrative Office all of items 1 through 6 except item number 3. Also do numbers 8, 9 and one of the following must also be submitted: 

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  - (a) Be licensed or certified in another state that has licensure or certification requirements substantially equivalent, as determined by the committee, to the requirements of the Tennessee "Clinical Perfusionist Act" (T.C.A. 63-28-101 et. seq). Please submit a copy of the rules in place when licensure or certification was awarded and have submitted to the Administrative Office proof of a current, active clinical perfusionists license/certificate that is in good standing and without any restriction or encumbrance in another state. Submit Attachment 1 to all licensure/certifications that apply. 

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  - (b) Cause to have submitted to the Administrative Office a current certificate as a certified clinical perfusionist issued by the ABCP. 

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## **Provisional License**

A provisional license may be issued to an applicant who has applied for but has yet to take the licensure examination. To obtain a provisional license an applicant must cause to be submitted to the Administrative Office all of items 1 through 6, and items 8 and 9 above and submit attachment 2 to the ABCP National Office. Applicants must have made application to sit for the licensure exam and sign the ABCP verification release form (attachment 2) allowing ABCP to release all exam scores to the Tennessee Board of Medical Examiners. Additionally, holders of a provisional license must work under the supervision and control of a licensed clinical perfusionist at all times during which clinical perfusion is performed. Therefore, please have your supervising clinical perfusionist(s) fill out Attachment 4 and return it to the Committee's administrative office.

## **UNDERSTANDING THE APPLICATION PROCESS**

**If an address change occurs at any time, you must notify the Committee's administrative office, in writing, immediately.**

1. All application fees and provisional licensure fees are non-refundable. Accordingly, please familiarize yourself with the laws, rules and requirements for licensure prior to submitting your application.
2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:  
  
Committee for Clinical Perfusionists  
665 Mainstream Drive, 2<sup>nd</sup> Floor  
Nashville, TN 37243
3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Committee asks that you please give the administrative office every consideration in this matter.
4. If necessary documentation has not been received when your application has been received by the Committee's administrative office, an initial deficiency letter will be sent to you. The supporting documentation requested in the letter must be received in the Committee's administrative office sixty (60) days from the date of the initial deficiency letter. **Files not completed within sixty (60) days may be closed.**
5. Absent any complicating factors, the average application processing time is eight (8) weeks. Once the application is completed, your file will be promptly reviewed and an initial certification determination made. You will be promptly notified by letter of the initial determination and if your application is approved you will be able to view certification approval online at: <http://tennessee.gov/health/>.
6. It is strongly recommended that you do not make arrangements to accept employment as a clinical perfusionist in Tennessee until you are granted a license by the Committee of Clinical Perfusionist.
7. All documents which are provided to this office in conjunction with your request for a medical license becomes part of the public record and must be released pursuant to a public records request.

Thank you for your cooperation. We will make every effort to process your application in an efficient manner.

**IMPORTANT: You must have a Tennessee license issued by the Committee of Clinical Perfusionists in your possession before you may lawfully practice.**



**FOR OFFICIAL USE  
ONLY**

**2984-001 \$250.00  
2984-006 \$ 10.00**

**ATTACH A  
CURRENT FULL-  
FACE  
PHOTOGRAPH**

**STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TN 37243**

**BOARD OF MEDICAL EXAMINERS  
COMMITTEE FOR CLINICAL PERFUSIONISTS  
(800) 778-4123, ext. 532-4384 or Local (615) 532-3202, ext. 532-4384  
[www.tennessee.gov](http://www.tennessee.gov)**

## **APPLICATION FOR LICENSED CLINICAL PERFUSIONIST**

Please **check** the appropriate category for which you are applying:

☐ License by Exam    ☐ License by Grandfather Clause    ☐ License by Reciprocity    ☐ Provisional License

### **PERSONAL INFORMATION**

#### **PLEASE PRINT IN INK**

Name as it will appear on license: \_\_\_\_\_  
(First) (Middle) (Last)

Have you been known by any other name?    Y    N    If yes, list names: \_\_\_\_\_

Date of Birth: Mo. \_\_\_\_ Day \_\_\_\_ Yr. \_\_\_\_    Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

U.S. Citizen:    Y    N    Are you entitled to Live and Work in U.S.?    Y    N

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces?    Y    N    (If yes, please provide proof of status.)

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component. (If yes, please provide proof of same.)    Y    N

Present Mailing Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
Gender: M    F    Race: \_\_\_\_\_

Email address: \_\_\_\_\_

Do you wish to receive notification, including renewal notification, from the Department of Health via email?    Y    N

**Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office.**

## EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of [this page](#) if you need additional space. (Send Attachment 4 to the educational institution where you completed your program.)

From:	_____	To:	_____	_____	_____
	MM/YY		MM/YY	Educational Institution	Location
From:	_____	To:	_____	_____	_____
	MM/YY		MM/YY	Educational Institution	Location
From:	_____	To:	_____	_____	_____
	MM/YY		MM/YY	Educational Institution	Location
From:	_____	To:	_____	_____	_____
	MM/YY		MM/YY	Educational Institution	Location

Please complete your entire employment history starting with the most current position first. Use the back of [this page](#) if you need additional space.

### DATES

### LOCATION

### POSITION AND DUTIES

From:	_____	To:	_____	_____	_____	_____
	MM/YY		MM/YY	(City)	(State)	
From:	_____	To:	_____	_____	_____	_____
	MM/YY		MM/YY	(City)	(State)	
From:	_____	To:	_____	_____	_____	_____
	MM/YY		MM/YY	(City)	(State)	
From:	_____	To:	_____	_____	_____	_____
	MM/YY		MM/YY	(City)	(State)	
From:	_____	To:	_____	_____	_____	_____
	MM/YY		MM/YY	(City)	(State)	
From:	_____	To:	_____	_____	_____	_____
	MM/YY		MM/YY	(City)	(State)	
From:	_____	To:	_____	_____	_____	_____
	MM/YY		MM/YY	(City)	(State)	
From:	_____	To:	_____	_____	_____	_____
	MM/YY		MM/YY	(City)	(State)	

## LICENSURE INFORMATION

**YES**   **NO**

Are you or have you ever been licensed in this profession in another state?

\_\_\_\_\_

Are you or have you ever been licensed in any other profession in Tennessee or another state?

\_\_\_\_\_

List below all states, countries or provinces in which you have ever been or currently are licensed, permitted or certified. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**YES**   **NO**

Have you ever previously applied for a clinical perfusionist license in Tennessee?

\_\_\_\_\_

Have you ever received a provisional license to practice as a clinical perfusionist in Tennessee?

\_\_\_\_\_

If you have an NPI number, please provide \_\_\_\_\_

## COMPETENCY INFORMATION

**PLEASE ANSWER THE FOLLOWING QUESTIONS.** If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. **In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
  - a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;
  - b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
  - c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.
3. **"Minor Traffic Offense"** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.
4. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
5. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
6. **"Illegal use of illicit or controlled substances"** means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

### QUESTIONS

YES NO

1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice? \_\_\_\_\_
2. Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety? \_\_\_\_\_

If so, please list: \_\_\_\_\_

*[If you receive such ongoing treatment or participate in such a monitoring program, the Committee will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]*

## COMPETENCY INFORMATION CONTINUED

**QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.**

- |     |  | YES | NO  |
|-----|--|-----|-----|
| 3.  | At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?  | ___ | ___ |
| 4.  | Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?   | ___ | ___ |
| 5.  | Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?  | ___ | ___ |
| 6.  | Have you ever held or applied for a license, privilege, registration or certificate to practice as a clinical perfusionist in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? | ___ | ___ |
| 7.  | Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?  | ___ | ___ |
| 8.  | Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?  | ___ | ___ |
| 9.  | Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?   | ___ | ___ |
| 10. | Have you ever been rejected or censured by a professional association or society?  | ___ | ___ |
| 11. | In relation to the performance of your professional services in any profession:  |     |     |
|     | a. Have you ever had a final judgment rendered against you;  | ___ | ___ |
|     | b. Have you ever entered into any settlement of any legal action; or   | ___ | ___ |
|     | c. Are there any legal actions pending against you or to which you are a party?  | ___ | ___ |
| 12. | Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?  | ___ | ___ |
| 13. | My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)   | ___ | ___ |
| 14. | Have you ever failed a licensure or certification examination?   | ___ | ___ |
|     | If yes, which exam and how many times have you failed? _____   |     |     |



**APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT**

**AFFIDAVIT AND RELEASE**

I, \_\_\_\_\_, of \_\_\_\_\_,  
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application and signed photos, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations which were enclosed in the application packet and agree to abide by them in the practice of my profession in the State of Tennessee.

**I HEREBY:**

**SIGNIFY** my willingness to appear to answer such questions as the Committee may find necessary which may include an interview.

**RELEASE** to the Committee and Board, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice my profession.

**AUTHORIZE** the Committee and Board, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and any other qualifications;

**RELEASE** from liability the Committee and Board, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and/or other qualifications for licensure.

**ACKNOWLEDGE** that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

**AUTHORIZE** release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

**AUTHORIZE** the American Board of Cardiovascular Perfusion National Office to release my exam scores directly to the State Board of Medical Examiners' Committee for Clinical Perfusionists.

**THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

ATTACHMENT 1



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TN 37243

COMMITTEE FOR CLINICAL PERFUSIONISTS  
(800) 778-4123, ext. 532-4384 or Local (615) 532-3202, ext. 532-4384  
[www.tennessee.gov](http://www.tennessee.gov)

CLEARANCE FROM OTHER STATE LICENSURE BOARDS

**APPLICANT:** Please provide the information requested in the top box and then mail one form to the licensure board in EACH state where you **hold or have ever held** a license to practice any profession. (Copies of this form can be used). **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

**To Be Completed By Applicant (Please Print In Ink)**

I, the undersigned applicant, was granted a **(circle one)** license or certificate to practice \_\_\_\_\_  
(Profession)  
numbered \_\_\_\_\_ on \_\_\_\_\_ in the State of \_\_\_\_\_.  
(Date)

The Committee of Clinical Perfusionists of Tennessee requests that I submit evidence of the current status of that license in your state.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Committee of Clinical Perfusionists.

Date \_\_\_\_\_ Applicant's Signature \_\_\_\_\_  
Applicant's typed or printed name \_\_\_\_\_

**To Be Completed By Administrative Office of State Licensure Board**

Name In Full As it Appears On License/Certificate or Permit:

\_\_\_\_\_  
(First) (M.I.) (Last)  
License/Certificate/Permit Number: \_\_\_\_\_ Profession: \_\_\_\_\_

Date Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Basis of Issuance: \_\_\_\_\_ Endorsement/Reciprocity with \_\_\_\_\_  
(Check One) (State)  
\_\_\_\_\_ Written Examination \_\_\_\_\_

Is the license currently active and registered? Yes \_\_\_\_\_ No \_\_\_\_\_  
Is there any derogatory information on file? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please attach supporting documentation.

Authorized Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Please mail directly to: Committee for Clinical Perfusionists  
665 Mainstream Drive  
Nashville, TN 37243



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DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
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[www.tennessee.gov](http://www.tennessee.gov)

**ABCP VERIFICATION**

Please complete this form and mail it to the address below:

**Send to:**

**American Board of Cardiovascular  
Perfusion National Office  
207 N. 25th Avenue  
Hattiesburg, MS 39401**

**To Be Completed By Applicant (Please Print In Ink)**

Dear ABCP Official:

I am applying for a license to practice as a Clinical Perfusionist in the State of Tennessee. By signing this document I authorize the American Board of Cardiovascular Perfusion National Office to release my exam scores directly to the State Board of Medical Examiners' Committee for Clinical Perfusionists.

Applicant's Name: \_\_\_\_\_  
(First) (Middle) (Last)

Social Security No.: \_\_\_\_\_  
Signature for Release of Information

**PLEASE MAIL SCORES DIRECTLY TO:**

**Committee for Clinical Perfusionists  
665 Mainstream Drive  
Nashville, TN 37243**

## ATTACHMENT 3



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TN 37243

COMMITTEE FOR CLINICAL PERFUSIONISTS  
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### TRANSCRIPT REQUEST

**APPLICANT:** supply the information requested in this box and then mail this entire form to your graduate school.

Full Name: _____		
(Last)	(First)	(Middle/Maiden)
Address: _____		Social Security Number: _____ - _____ - _____
_____		
_____		
_____		
Student Identification Number: _____		
Year of Graduation: _____		
Degree Obtained: _____		

### TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a clinical perfusionist in the State of Tennessee. Please forward an original graduate transcript bearing the institution's official seal to:

**Tennessee Board of Medical Examiners  
Committee for Clinical Perfusionist  
665 Mainstream Drive  
Nashville, TN 37243**

Thank you for cooperation and prompt response.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date



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**SUPERVISING LICENSED CLINICAL PERFUSIONIST**

This section must be completed by the supervising clinical perfusionist(s).  
(This page may be duplicated if necessary)

**List all practice settings:**

1) **Setting:**

\_\_\_\_\_  
Supervising Clinical Perfusionist

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee License Number

2) **Setting:**

\_\_\_\_\_  
Supervising Clinical Perfusionist

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee License Number

3) **Setting:**

\_\_\_\_\_  
Supervising Clinical Perfusionist

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee License Number

4) **Setting:**

\_\_\_\_\_  
Supervising Clinical Perfusionist

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Tennessee License Number



STATE OF TENNESSEE  
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**DECLARATION OF CITIZENSHIP**  
**MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE**

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) \_\_\_\_\_  
Healthcare Profession (Please Print)                      License number if applicable

**Please Print Legibly**

1. Name: \_\_\_\_\_  
Last                      First                      Middle                      Maiden
2. Mailing Address: \_\_\_\_\_
3. Phone Number: Home: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Office: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_
4. I am a United States Citizen:    \_\_\_\_Yes    \_\_\_\_No
5. I am a foreign national not physically present in the United States \_\_\_\_Yes \_\_\_\_No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
  - a) Tennessee Driver's License, or photo ID issued by the Tennessee Department of Safety.
  - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Tennessee Department of Safety criteria.
  - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not qualify.
  - d) A federally issued birth certificate.
  - e) A valid, unexpired U.S. passport.
  - f) A report of birth abroad of a U.S. citizen.
  - g) A certificate of citizenship.
  - h) A certificate of naturalization.
  - i) A U.S. citizen ID card.
  - j) Any successor document to #'s e-i above.
  - k) An SSN that is verifiable with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
  - a) Permanent Resident
  - b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
  - c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
  - d) Refugees who meet the qualifications set out in 8 U.S.C. 1157

- e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status- "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Signature

Sworn to before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires:\_\_\_\_\_

**If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of citizenship or alien status, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney and/or the Office of the Attorney General.**